SPARKS DENTAL CLINIC **Patient History Form**

Update as needed

Patient's Name:			**Date of Birth**	**Pt's living status**
Nickname:		Sex: Male ☐ Female ☐	Race: Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Other (specify)	At home (with family) ☐ Group home (name) ☐ _____

Payor Information: Provide information for person responsible for payment for treatment services			
Name: Name (please print) Relationship		Address:	
		Phone #:	Primary Secondary
Dental insurance:		Insurance Contract #:	

Legal Guardian: Provide contact information for person with legal authority to consent to patient's treatment			
Name: Name (please print) Relationship		Address:	
		Phone #:	Primary Secondary

Medical Contact: Provide contact information for person who can answer questions about patient's medical history			
Name: Name (please print) Relationship		Address:	
		Phone #:	Primary Secondary
Primary Care Physician:	Name		Phone number
Specialists Physician:	Name	Specialty	Phone number
Specialist Physician:	Name	Specialty	Phone number
Pharmacy of choice	Name		Phone number

BEHAVIORAL HISTORY		
How well does the patient communicate:	☐ Verbal ☐ non- verbal ☐ sign language ☐ lip reading ☐ Other _____	
At what level does the patient understand?	☐ Normal for age ☐ No understanding ☐ Limited understanding, like a ____ year old	
How well does the patient walk/move?	☐ normal movement ☐ Requires assistance ☐ walker ☐ wheelchair	
Do you anticipate the patient being cooperative for dental care?	☐ Yes ☐ No _____	
Has past dental care been easy for patient to tolerate?	Yes ☐ No ☐	Explain:
If the patient becomes uncooperative, who is authorized to decide about using advanced behavior management methods?	Name Relationship Phone number	

DIET HISTORY	
Patient's typical diet is:	☐ Regular ☐ Liquid ☐ Soft ☐ tube-fed
In a normal day, what does the patient drink the most?	
List any dietary supplements the patient takes:	_____

HYGEINE HISTORY		
Does patient brush their own teeth?	Yes ☐ No ☐	If No, who brushes for them?
How often are the teeth brushed?	☐ 1x/day ☐ 2x/day ☐ 3-5x/week ☐ Other_____	

DENTAL HISTORY			
Check types of dental care patient received in past:	☐ No past visits ☐ Exams ☐ Cleanings ☐ Fillings/Extractions		
Previous dental visit:	Dentist/Office name (please print)	phone number	Last dental visit (When?)
Can patient physically sit in a dental chair?	Yes ☐ No ☐		
Has sedation or general anesthesia been required?	Yes ☐ No ☐	If Yes, what sedatives have been used?	

SIGNATURE _____ (_____) _____

Patient/Parent/ Guardian **Date**

_____ (_____) _____

Dentist **Date**